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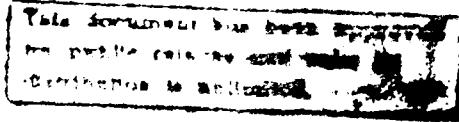
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ESTABLISHMENT OF A SEPARATE PSYCHOLOGY SERVICE AT
WALTER REED ARMY MEDICAL CENTER

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HEALTH SERVICES COMMAND
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ESTABLISHMENT OF A SEPARATE PSYCHOLOGY SERVICE AT WALTER REED ARMY MEDICAL CENTER

Psychology has been both a science and a health care profession for over 100 years. Efficient and effective treatments for mental disorders have been developed which allow for outpatient care. Psychology as a health care profession has grown. As of mid-1985, there were approximately 45,000 psychologists licensed or certified for independent practice. Of those doctoral level psychologists surveyed in a 1983 study of all psychology personnel living in the United States, 14.6% reported their primary employment to be in a hospital setting, with an additional 3.9% based in medical schools (Stapp, Tucker, & VandenBos, 1985). Hospital based clinical privileges, when available to psychologists, were restricted or required physician supervision or signoff. As of 1980, only 3% of psychologists could admit patients without the signature of a physician and even fewer could discharge patients independently (Dorken, Webb, & Zaro, 1980). In Army hospitals, Psychology Services have been administratively under the Department of Psychiatry.

Purpose

The National Defense Appropriations Act for Fiscal Year 1988 required the establishment and evaluation of a separate Department of Psychology at an Army installation (see Appendix 1). A separate psychology service was established at Walter Reed Army Medical Center on 1 May 1988. An implementation plan and evaluation program were required. This study will detail the implementation plan (Appendix 2) and evaluation of the separate psychology service (Appendix 3).

Background

This report concerns utilization of clinical psychology in the civilian and federal health care sectors. It will be concerned with the following areas:

- a) Professional training and qualifications
- b) Ethical standards
- c) Current statutes and guidelines
- d) Current emphasis of clinical psychology on health and wellness
- e) Precedents for separating clinical psychology from Departments of Psychiatry
- f) Uniformed military psychologists
- g) Retention of non-physician health care providers.

Professional Training and Qualifications

Psychology is the scientific study of behavior. There is a broad base of knowledge derived from scientific and clinical investigations and applications of theories of behavior. To use the title "psychologist," an individual has earned a doctoral degree from a regionally accredited institution. The graduate training includes a general core curriculum of a minimum of 90 semester hours in psychology plus scientific research projects. A health service provider completes a doctoral degree (usually in four years), an American Psychological Association accredited and approved psychology internship (one year), and at least one additional year of supervised post-doctoral experience. For licensure as a psychologist, an individual sits the standardized test developed by the Professional Examination Service with the American Association of State Psychology Boards. Individual state Boards of Examiners may require additional supervised experience and examinations as well for licensure as a psychologist.

The National Register of Health Service Providers in Psychology has served since 1975 to identify licensed or certified psychologists qualified to provide health services. The Register defines a health service provider in psychology as "a certified/licensed psychologist at the independent practice level in his/her own state, who is duly trained and experienced in the delivery of direct preventive, assessment, and therapeutic intervention services to individuals whose growth, adjustment, or functioning is actually impaired or is demonstrably at high risk of impairment." In 1987, over 15,000 psychologists were listed in the National Register of Health Service Providers in Psychology.

Ethical Standards

Psychologists are required to follow the Ethical Principles of Psychologists developed by the American Psychological Association (1981). The APA Ethical Principles require that psychologists limit their practice to those areas in which they have developed professional competence through training and experience. The expected levels of professionalism for psychologists are explained in the General Guidelines for Providers of Psychological Services (1987). Psychologists "pursue their activities as members of the independent, autonomous profession of psychology" (Article 3.2). Psychologists in the federal health care sector are required to adhere to the Ethical Principles and the federal regulations governing delivery of health care services.

Current Statutes and Guidelines

In 1980, California established a hospital practice act providing for the granting of hospital staff privileges to psychologists. Georgia (1982) and the District of Columbia (1983) passed similar legislation. North Carolina (1983) amended the hospital practice act to include other health practitioners as eligible for privileges. Psychologists in many other states have begun to lobby for more independent practice in hospitals (Bersoff, 1983; Dorken, 1981; Tanney, 1983).

Since 1975, the National Register of Health Service Providers in Psychology has been recognized as identifying qualified providers of psychological services to Civilian Health and Medical Program for the Uniformed Services (CHAMPUS), the Aetna and Blue Cross/Blue Shield Federal Employees Health Benefits Plans, and other groups. The CHAMPUS plan, the Federal Employees Plan, and other private plans reimburse psychologists as independent providers of services. Information about psychological health care and public policy can be found in Psychology and National Health Insurance: A Sourcebook (Kiesler, Cummings, & VandenBos, 1979) or Professional Psychology in Transition: Meeting Today's Challenges (Dorken & Associates, 1986). A Hospital Practice Primer for Psychologists (1985), developed by the Committee on Professional Practice of the Board of Professional Affairs of the American Psychological Association, describes hospital privileges and practice patterns for psychologists.

The Joint Commission on the Accreditation of Hospitals Accreditation Manual for Hospitals (1984) recognizes "other licensed individuals permitted by law and by the hospital to provide patient care services independently within the scope of their clinical privileges." Clinical privileges are based on the criteria established by the hospital.

Army Regulation 40-216 "Neuropsychiatry and Mental Health" prescribes the policies and concepts regarding neuropsychiatry principles for mental health staff and facilities. As defined in AR 40-216, the psychologist "is required to apply the principles of psychology to assess and resolve mental and behavioral disorders and to reduce incidents of preventable mental disorders." Health Services Command Regulation 40-3 "Use and Control of Psychological Test Materials," prescribes policy and procedures on the use and control of psychological test materials. "Psychological tests are administered, scored, and interpreted only in situations having the professional supervision and accountability of a qualified psychologist."

Current Emphasis of Clinical Psychology On Health and Wellness

In clinical psychology, the era following World War II was noted for a decline in interest in psychological assessment. Psychologists began establishing roles as psychotherapists rather than testers. Greater involvement by psychologists in behavior modification, health screening, and health promotion has been evidenced by the creation of the Division of Health Psychology in the American Psychological Association in 1979. The purposes of the Division of Health Psychology are to advance contributions of psychology as a discipline to the understanding of health and illness through basic and clinical research and by encouraging the integration of biomedical information about health and illness with current psychological knowledge; to promote education and services in the psychology of health and illness; and to inform the psychological and biomedical community and the general public on the results of current research and service activities.

According to the Report of the Surgeon General of the United States (1979) entitled Healthy People: Health Promotion and Disease Prevention, 75% of all deaths in the United States are due to chronic degenerative disease, with the major risk factors being environmental and behavioral. The impairment of performance, decrease in potential, loss of productivity, and unnecessary utilization of health care services are creating a severe strain on health care facilities. Industrial managers are recognizing the importance of providing support services and employee assistance programs to company employees. Other corporate strategies include physical fitness programs, health risk appraisals, stress management, and wellness programs. Industrial wellness programs are perceived as being in corporate financial self interest.

The use of appropriate mental health services to reduce the use of medical services has been demonstrated (Jones & Vischi, 1979). It has been estimated that as many as 60% of total patient visits to physicians are related to emotional problems; this information comes from the twenty years of experience with the Kaiser-Permanente program (Cummings & VandenBos, 1981).

Clinical psychologists have been influential in the wellness movement. The major health problems of contemporary society involve behaviors and lifestyles which interfere with the individual's ability to perform at optimal levels and significantly contribute to the development of illness and disability. Clinical psychology has shifted away from the assessment and treatment of mental illness to health promotion and the prevention of mental, emotional, and physical dysfunction.

Precedents for Separating Clinical Psychology From Departments of Psychiatry

Recognition of the range of contributions made by psychologists in the delivery of health services has resulted in the establishment of separate psychology departments or services in several medical schools and health care centers. The Department of Medical Psychology at the University of Oregon Health Sciences Center was established in 1961. Departments of Medical Psychology function well at the Uniformed Services University of the Health Sciences, the Veterans Administration, and at the University Medical Schools in Florida, U.C.L.A., and others (Lubin, Nathan, Matarazzo, 1978). A separate Psychology Department was established at the Naval Hospital, Bethesda, Maryland, in 1987; it continues to function well.

Direct access to the psychology service allows for increased support to a variety of medical specialties. Consultation/liaison functions with other specialties can be enhanced. Pediatrics services can be advised on subtle and complex issues associated with developmental and educational problems. Preventive health programs can be developed for children and adolescents. Orthopedics services can be helped with chronic pain patients. OB/GYN patients can be assisted with decreasing anxiety and discomfort associated with childbirth or with sexual dysfunction. Surgical patients with chronic pain can be assessed and treated. Urology patients can be assisted with sexual dysfunction issues. Patients with chronic headache or muscle tension problems can be evaluated and treated. Assessment of lifestyle or behaviors for cardiovascular risk can be made. Stress management, weight control, smoking cessation, sleep disorders, pain management, anxiety disorders, and other behavior modification programs can be developed. Psychodiagnostic consultation can support Neurology and Psychiatry. Multi-disciplinary consultation allows for blending the knowledge and skills of a variety of disciplines to benefit the patient. Consultation by an independent psychology service allows for more optimal health care to be delivered to patients. Administratively, an independent service has greater control over its personnel and financial resources.

Uniformed Military Psychologists

The use of clinical psychologists by the military services has risen dramatically. In 1969, the Air Force had 33 clinical psychologists, the Navy 43, and the Army had 66 applied psychologists. In 1989, the numbers of uniformed psychologists had increased to 175 Air Force clinical psychology billets, 112 Navy billets, and 124 Army clinical psychologist positions. These trends parallel those developing in the civilian community concerning the increase in the number and utilization of clinical psychologists in promoting and improving health care.

In the history of Army clinical psychology, several trends have been evident (Nichols, 1982; Mangelsdorff, 1978, 1984, 1989). Army clinical psychologists regard themselves as psychologists first and Army officers second. They remain satisfied with their status in the military only as long as their professional role and status compare favorably with that of their civilian clinical counterparts. Few clinical psychologists have made a career in the Army Medical Department (AMEDD) as medical service corps officers.

There have been several cycles evident in the retention of Army clinical psychologists. In general, the retention of Army psychologists has been poor. Once pay-back time for training is completed, most Army clinical psychologists leave the service. Recruitment of psychologists was most

effective through the internship training programs such as the Graduate Student Program (GSP) during the 1950s through the 1970s. The GSP was a major source for recruiting prior service military officers and training them as clinical psychologists: a significant number of the prior service officers who became psychologists remained on active duty until eligible to retire in the 1980s (Mangelsdorff, 1989). The GSP was followed by the Health Professions Scholarship Program (HPSP) which stopped accepting psychologists in the mid-1980s. The cutoff in the HPSP training authorizations reduced the number of incoming psychologists. Changes in the number of years for pay-back for internship training have affected recruitment, as has competition from Navy and Air Force training programs.

The retention of Army clinical psychologists for a military career has been problematic for many reasons (Nichols, 1982; Thomas, 1982). Since 1950, fewer than fifteen Army psychologists have made full colonel and fewer than 40 have stayed long enough to retire at 20 years. The number of authorizations has declined or remained static. Until the early 1980s, most authorizations were for company grade positions only. The promotion selection rates for psychologists in the primary zone in 1987 were poor (35% to 04; 50% to 05; and 0% to 06). The selection rates in 1988 were again low (40% for 04; 0% for 06). The 1985 DoD requirement that all health care professionals (to include clinical psychologists) obtain and maintain a state license has been troublesome. At the end of 1988, of the 124 psychology officers only 63 reported being licensed as psychologists. The DoD licensing requirement affects recruitment of civilian psychologists; it affects retention as licensed psychologists are paid higher salaries in the civilian sector. Several congressional bills have been introduced to provide additional pay to board certified psychologists; no funds have been authorized. The MSC Study recommended clinical psychology be retained as a specialty and that additional 06 authorizations be determined for clinical psychologists.

Retention of Non-physician Health Care Providers

The DoD Task Force on Non-physician health care providers has been interested in the morale of the non-physician health care providers. A Defense Audit Service report (Meling, 1982) interviewed many military clinical psychologists, optometrists, pharmacists, podiatrists, and physician assistants. There were significant morale problems noted. There was a need for more professional recognition (particularly of psychologists). There were limitations on the scope of practice (mostly affecting psychologists and optometrists who could not practice independently in the military), limited promotion opportunities, pay inequities, difficulties obtaining command and management experience, and perceived irrelevance of administrative duties. The retention rate for uniformed psychologists, particularly for company grade officers, has been a concern (Mangelsdorff, 1978, 1984, 1989). In recent years, the Army clinical psychologists have experienced the lowest retention, accession, and promotion rates of the three armed Services. The low promotion rates (at 04 and 06) have been directly linked to low retention rates. The absence of authorized 05 positions and limited opportunities for leadership experience have hurt psychology career opportunities (Mangelsdorff, 1989).

OBJECTIVES

The study objectives are to (1) develop an implementation plan for organizing the psychology service and (2) develop and conduct an evaluation of the effects of the separate psychology service.

METHOD

Overview

Missions, personnel, and organizational structure were defined for the Walter Reed Army Medical Center (WRAMC) Psychology Service. Productivity measures were examined. Quality measures of complaints, staff satisfaction, patient satisfaction, access, and external/internal quality review were conducted.

Procedure

Surveys were developed to determine (1) information about the clinic missions, personnel, and organization; (2) productivity measures of workload; (3) quality measures of staff satisfaction and patient satisfaction. The surveys were administered during each quarter. Open ended questions were used to compare retrospectively how the service operated before becoming separate and after establishment of the separate Psychology service. Psychiatry staff members were surveyed for comparison as well.

FINDINGS

Psychology Missions, Personnel, and Organization

The overall mission of the psychology service at Walter Reed Army Medical Center is (1) to provide and coordinate psychological services for all patients with the highest standards of quality patient care and (2) to conduct a clinical psychology internship training program and support the various medical residency and fellowship programs. These services include evaluation, diagnosis, treatment, consultation, referral, and disposition. The separate Psychology Service was established on 1 May 1988. The Psychology Service is one of 18 separate departments and services reporting directly to the Deputy Commander for Clinical Services.

Training Mission

The training mission of the psychology service is to train four psychology interns. Three to four full time Ph.D. equivalent personnel are required to support this training. The psychology internship training program is accredited by the American Psychological Association; the internship program accreditation was renewed in 1985. Other training programs supported by the Psychology Service include Psychiatry residencies; child Psychiatry fellowships; pediatric, neurology, and neurosurgery residencies; and USUHS medical students. Approximately 50% of staff time and service resources support the training mission.

During FY 88, Psychology staff participated in a variety of continuing education experiences. These included in service training, grand rounds, professional conferences, seminars, and workshops.

The percentages of time spent in supervision of subordinates ranged from 10 to 50%, with a median of 25%. The percentage of time spent in formal teaching ranged from 5 to 30%, with a median of 10%.

Of the staff members, seven of eight are licensed as psychologists. There are two staff who are board certified diplomates in psychology.

Readiness Mission

The readiness mission involves one person. The resources are dedicated to the readiness mission 40-60% of the time.

Personnel

As of May, 1989, the working TDA called for six military psychologists, seven civilian psychologists, two civilian psychology technicians, four Behavioral Science Specialists (91Gs), and one civilian secretary. Four psychology interns are trained each year. There are 16 recognized requirements, 14 authorizations, and 15 assigned personnel. Additionally, there is one regular civilian consultant who provides group therapy training for the psychology interns. Two civilian neuropsychologists provide services to active duty soldiers through supplemental care funds. Figure 1 details the Psychology Service personnel.

Organization

The psychology service is organized into several sections: Psychiatric Inpatient and Neuropsychology, Outpatient and Pediatric Psychology, Behavioral Medicine Consultation, and Training and Research. Workload is not broken down by section, but is summarized as Psychology Service. Figure 1 summarizes the organizational structure.

PRODUCTIVITY MEASURES

Patient Administration Systems and Biostatistics Activity, HSC (PASBA) extracted workload measures from the MED 302 reports for inpatient visits, outpatient visits, and psychological tests for calendar years 1987, 1988, and 1989. Table 1 reports the monthly productivity data extracted from the MED 302 reports. There is not a mechanism now available to track referrals and consultations to the Psychology Service from other clinics at WRAMC.

QUALITY MEASURES

Survey instruments were used to measure staff satisfaction (see Appendix 4 for the retrospective survey used in the first quarter and Appendix 5 for the primary survey instrument) and of patient satisfaction (see Appendix 6). The staff satisfaction surveys were administered each quarter. Staff turnover was documented. Interviews on site with staff and support personnel were conducted. The patient satisfaction survey was administered in May and June 1989.

Complaints

No documented complaints were recorded.

Staff Satisfaction

Descriptive statistics were calculated for the survey items. Comparisons were made between Staff Psychologists, Assistants/technicians/administrative support personnel and personnel In training (see Tables 2 and 3). Open ended questions were asked to compare retrospectively how the service operated before becoming separate and also how the service operated after the separation.

Psychology Staff Satisfaction

Responses to the 7-point Likert scale items showed that the Psychology staff was most satisfied with the "staff emphasis on providing quality patient care," "extent to which staff is encouraged to be self sufficient," "knowing what is expected of them daily," and having the support of their co-workers and supervisor. Issues of significant dissatisfaction included "the availability of adequate support personnel, "the availability of adequate equipment supporting my job," and "the extent the physical surroundings contribute to staff satisfaction with the work environment."

Comparisons were made between the responses of the Staff Psychologists, the Assistants/Administrative staff, and the Psychology Interns In Training on the Likert scale items. There were significant differences between the groups on "the availability of adequate equipment supporting my job," "obtaining licensure/certification while on active duty," "having opportunities available to work off duty," "the staff emphasis on providing quality patient care, and "the extent our staff receives cooperation from other departments." Tables 2 and 3 depict the results. The Interns In Training were most dissatisfied with the "availability of adequate equipment supporting my job" and "having opportunities available to work off duty." The Assistants/Administrative staff were most satisfied with the "staff emphasis on providing quality patient care." The Assistants/Administrative staff were least satisfied with "the extent feel being utilized professionally," "the extent our staff receives cooperation from other departments" and "obtaining licensure/certification while on active duty."

Psychology Under Psychiatry

Responses to the open ended question retrospectively describing how the Psychology Service operated before becoming a separate service were quite revealing. The Staff Psychologists felt they were treated as second class personnel who were not accorded professional respect or recognition. Inequities were perceived in terms of the availability of support personnel, TDY funding, supplies and equipment the psychologists received, patient charting, and administrative procedures. Psychological services were not fully recognized or used. Psychiatry staff was not as supportive as they could have been. The Interns reported feeling little primary responsibility, as the patients were staffed through Psychiatry.

Separate Psychology Service

After the separation occurred, respondents from the Psychology Service felt they had significantly more control over their own resources, equipment, funds, and missions. The staff morale was perceived as greatly improved, particularly among those who had previously worked under Psychiatry. With successive surveys, the overall levels of staff morale were perceived to increase. Significant personnel turnover, lack of replacements, retirement of key personnel, and illnesses were notable during the test period.

As perceived by the Psychology staff, the relationship of the Psychology staff with Psychiatry remains good at the personal level, but cool at the organizational level. Professional cooperation continues, though some tension is present. More support staff are needed for both Psychology and Psychiatry.

The Psychology staff reports gaining confidence in its abilities. The positive effects of being able to control Psychology Service budgetary and manpower resources seem to be greater than the additional administrative workload and responsibilities incurred by being separate. Greater interdisciplinary cooperation on patient care is developing as more contacts with other departments are occurring. More interdisciplinary training opportunities are needed.

Department of Psychiatry Staff Perceptions

Psychiatry staff satisfaction surveys were administered by the Department of Psychiatry; the response rate was representative (6 of 11 officer staff, 14 of 27 trainees; 21 responses were used). The officer staff reported the most satisfaction with the issues of "The support of my supervisor," "Having colleagues available for professional growth and development," "My liking my present position," and "The staff emphasis on providing quality patient care." The officer staff reported the least satisfaction with "The availability of adequate support personnel" and "Having opportunities available to work off duty (e.g. moonlight)."

The Psychiatry residents in training reported the most satisfaction with "The support of my coworkers," "Obtaining licensure/certification while on active duty," and "The amount of responsibility given to me." The trainees reported the least satisfaction with "The availability of adequate support personnel," "Having opportunities available to work off duty (e.g. moonlight)," "The availability of adequate equipment supporting my job," "Having a supportive duty environment," "The extent management is supportive of the staff," and "The extent our staff receives cooperation from other departments."

For the Psychiatry staff, the lack of support personnel and adequate equipment was a concern. With the establishment of the separate Psychology Service, psychological testing of patients was not as accessible nor were there as many referrals made to Psychiatry as previously. Psychiatrists were concerned whether psychologists could make appropriate assessments, particularly of organic conditions. Several staff psychiatrists expressed disapproval of the separate Psychology Service, believing the psychologists to be delusional in their euphoria. Many of the issues raised by the Psychiatry staff echoed concerns expressed by the American Psychiatric Association regarding the abilities of psychologists to function as independent practitioners.

As perceived by the Psychiatry staff, the relationship of Psychiatry with Psychology appears good at the personal level, but distant at other levels. Multidisciplinary patient care consultation continues. There was support from Psychiatry for the establishment of a Department of Mental Health which would foster multidisciplinary approaches and more comprehensive mental health care. Some physicians believed they should supervise, direct, rate, and command all professional staff. It was felt Psychology interns would not be exposed to as diverse a mixture of patients. Many Psychiatry staff members felt little had changed or were not aware of any differences since the separation.

Psychology and Psychiatry Staff Perceptions

ANOVAs were conducted between the staff satisfaction survey responses of Psychology and Psychiatry staff members. Table 4 depicts the significant differences in the 2x3 ANOVAs. There were differences between Psychology and Psychiatry for "The availability of adequate support personnel," "The extent management is supportive of the staff," and "The extent our staff receives cooperation from other departments." There were differences between the types of staff members for "The extent the staff know what is expected of them daily." There were no significant interaction effects in the 2x3 ANOVAs.

One-way ANOVAs were conducted between selected groups of Psychology and Psychiatry staff. There were significant differences between the officer Staff members on "The availability of adequate support personnel" ($p = .026$), "The amount of responsibility given to me" ($p = .020$), "The extent to which staff is encouraged to be self sufficient" ($p = .049$), and "The extent our staff receives cooperation from other departments" ($p = .001$). There were significant differences between the In Training personnel with respect to "The extent our staff receives cooperation from other departments" ($p = .001$) and "The extent management is supportive of the staff" ($p = .013$). The Psychology staff members were significantly more satisfied for all items reported.

Future Expectations for Separate Service

The open ended question for expectation in the future showed much optimism and hope. The Staff Psychologists expected to feel professionally respected and well utilized. Expectations were to have more timely fiscal support and control over support personnel, TDY funding, supplies and equipment, psychological treatment charts and procedures, continuing education programs, professional recognition, and respect. More psychological services were expected to be provided to enhance the quality of patient care. Professional health care services to referred patients were anticipated to be enhanced. The separate service was expected to enhance the psychologists' self image and professional pride. The autonomy should provide opportunities for creative leadership, self determination, professional growth, control over professional career, and more avenues for advancement. There was an expectation for more time being spent in administrative duties and hospital committee meetings. The Interns felt they would be more autonomous concerning patient care and be able to show more initiative in terms of patient care and research. The Assistants/Administrative staff were concerned about making future deadlines and requirements without additional support personnel. Work levels were projected to increase. Greater opportunities for professional give-and-take were expected. More research opportunities were deemed possible. Psychology staff cohesion and morale are expected to increase.

Patient Satisfaction

Responses from 70 outpatient encounters were recorded; responses were received from 66 patients. In general, patients reported being very satisfied with "concern for your privacy," "the care provider," and the "overall care received." The least satisfaction expressed by many of the respondents was with "the parking facilities," "the directions within the hospital," "the waiting time before being seen for treatment," "waiting time to obtain an appointment," and "explanation of your treatment/follow-up." There were significant differences between the categories of beneficiaries for "satisfaction with the clinic receptionist"; the Active Duty troops were the least satisfied group.

Access

The waiting time for appointments averaged one week, with two weeks being the latest for outpatient services. Two days was the maximum waiting time for inpatients. Certificates of non-availability were issued beginning May 1989 to 15% of outpatients referred out under CHAMPUS.

External/Internal Quality Review

A quality assurance program was developed for the Psychology Service. The plan defines the areas of responsibility and scope of care (see Appendix 8).

DISCUSSION

In examining the workload reported in the MED 302 reports, it was noted there were trends toward increased productivity in the number of outpatient visits reported since May, 1988, in comparison to that reported in 1987. Since the Psychology Service is a psychology internship training program and supports a number of other medical services, variations in workload will be expected as a function of the number of referrals made to psychology and in what part of the training curriculum the Psychology Interns are engaged. When the WRAMC Patient Administration Division brings on-line a patient tracking system which includes the Psychology Service, it will be easier to determine the effects of separating out the Psychology Service. Some miscoding of workload reported led to under reporting in the MED 302 reports; the changes are being made.

The separate psychology program was organized as a service rather than as a department. There were several factors which affected the decision to create a Psychology Service; these included the small number of personnel involved, the costs of running and administrating a department rather than a service, and the restriction that no additional support personnel were available. Discussions with COL Johnson (Deputy Commander for Administration at WRAMC) produced an agreement that an 06 position be authorized for the Chief of the Psychology Service. An authorized 06 position for the chief of the Psychology training program would allow psychologists enhanced opportunities for command, leadership, responsibility, and career progression. The authorized 06 position was not recorded on the last WRAMC TDA.

While administratively under the Psychiatry Department, the psychology staff perceived itself as not being professionally recognized or used to its fullest capabilities. Inequities were reported concerning professional recognition, availability of support personnel, TDY funding, supplies and equipment, and administrative procedures. There were limitations on the scope of practice. Historically, these same issues have been significant sources of dissatisfaction for military psychologists (Hedlund, 1968; Mangelsdorff, 1978, 1984, 1989; Meling, 1982; Murray, 1978). The morale of the psychology staff was not very high while under the Department of Psychiatry.

The reorganization as a separate psychology service is providing greater perceived autonomy and control to the psychology staff. The scope of practice is expanding, which should benefit a number of medical specialties. Consultation/liaison functions with other specialties will be enhanced. Psychodiagnostic consultation support to Neurology and Psychiatry will continue. Opportunities showing new initiatives in patient care and research are developing. Similar phenomena were reported when other groups separated from Psychiatry in the past (such as Neurology and Social Work which subsequently formed separate services at WRAMC).

The separate Psychology Service at WRAMC allows psychologists to obtain command and management experience. Control over support personnel, TDY funding, supplies and equipment, continuing education programs, and administrative procedures has been enhanced. Psychologists' self image and professional pride are increasing, as is their professional recognition. Now, the WRAMC psychology staff has the opportunity to manage its own resources and prove its contributions and capabilities. The psychology staff can share their skills to enhance the quality of patient care provided.

The increased use of clinical psychologists by the military services has not been paralleled by the development of appropriate career progression, recognition, and retention programs. The Army Graduate Student Program during the 1970s allowed significant numbers of career officers (with several years of military experience) to obtain advanced graduate degrees and training as clinical psychologists. However, the lack of authorized field positions hampered AMEDD career progressions.

The Army internship training programs have been barely adequate for bringing in new psychologists. Military personnel policies, poor pay, poor promotion opportunities, and limited career opportunities have contributed to low retention rates of junior officers. There have been very few psychologists who were trained in Army programs as interns and remained to retire from the military, who were not previously military officers (Mangelsdorff, 1989). The absence of a Graduate Student Program and the lack of Health Professions Scholarship Program authorizations are hurting Army Clinical Psychology.

The introduction of four post-doctoral training programs temporarily helped retain more mid-career psychologists in the early 1980s. However, recently the low pay in comparison to civilian peers, poor promotion policies for the O5 officers, and lack of O6 authorizations have resulted in significant numbers of LTC clinical psychologists exiting the Army at 20 years of service. While the AMEDD has been slow to respond, other Army opportunities have been evolving. There are a significant number of senior Army officers who were trained as clinical psychologists under the Graduate Student Program, but seeing the lack of an adequate career progression for themselves as clinical psychologists transferred to non-psychologist command and staff positions to further their military careers. In addition, significant programs for clinical psychologists are being developed in special operations. The Army has found clinical psychologists useful to enhancing soldier performance and sustaining the fighting force; the medical community has been less responsive in recognizing clinical psychology. The Army research psychology community has been well recognized by the Office of the Deputy Chief of Staff for Personnel (ODCSPER) and the Special Operations Command for the contributions to combat stress, disaster management, stress prevention and health promotion, continuous and

sustained operations, enhancement of military performance, unit cohesion, leadership, and selection and training in special operations.

It is for the very reasons of inadequate career progression as medical service corps officers, low accessions, poor promotion and low retention rates, poor professional compensation, and limited leadership opportunities for Army clinical psychologists that separate Psychology Service programs needed to be developed. The military has recognized the contributions psychology has made, as attested by the increased number of clinical psychology positions developed from 1969 to 1989. Providing appropriate role models for incoming psychology interns, establishing additional training opportunities for mid-career clinical psychologists, offering competitive career progressions, and developing meaningful leadership opportunities are crucial to the maintenance and enhancement of Army clinical psychology. This evolution must come from Army psychologists who are competent practitioners/clinicians, military officers, and leaders willing to share their consultative skills in interdisciplinary settings. The contributions of military psychology will have to be recognized, understood, and appreciated by both the line and the medical communities; only the Special Operations areas have begun to tap the resources available from psychology. Ultimately, the line will decide what resources are essential to supporting the Army missions.

The organization and training program at WRAMC is unique. Establishing separate Psychology Services at other Medical Centers having training programs will have to be configured to specific staffs, available resources, and missions. The success of the separate Psychology Services will be dependent upon the cooperation received from the medical and health care staffs. Professional competition between specialty groups has to be put aside for promoting the general mission of the Army medical community; to sustain the fighting force.

In the civilian sector, a significant competition between psychologists and other health care providers has been developing. The amount of energy being diverted into this economic competition is becoming staggering; it would be much better for the health care system if the professional energies were channeled into cooperative programs. Interdisciplinary consultation and liaison functions which benefit many health care specialties are critical. Psychology will gain additional respect and recognition as it proves the uniqueness of its contributions to enhancing overall patient care. The military health care system has the unique opportunity to show how cooperative programs can develop and function to provide effective prevention and treatment programs to the military community and to support the readiness missions.

RECOMMENDATIONS

Separate Psychology Services should be established at other Medical Centers having training programs (Eisenhower AMC, Madigan AMC, and Tripler AMC). The separate Psychology Services will have to be configured to specific staffs, available resources, and missions. To enhance leadership opportunities and career progression for clinical psychologists, an authorized 06 position needs to be created for each separate Psychology Service. Professional competition between specialty groups has to be put aside for promoting the general mission of the Army medical community; to sustain the fighting force.

Figure 1
Organizational Structure of WRAMC Psychology Service

Office of
the Chief

Neuropsychology and Inpatient Psychiatric Psychology Section	Behavioral Medicine Section	Outpatient and Pediatric Psychology Section	Training and Research Section
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Psychology Service Table of Distribution and Allowances
Walter Reed Army Medical Center

<u>PARA</u>	<u>LINE</u>	<u>DESCRIPTION</u>	<u>GR</u>	<u>MOS</u>	<u>BR</u>	<u>STRENGTH</u>	<u>REQ</u>	<u>AUTH</u>	<u>ASSGN</u>
OFFICE OF THE CHIEF									
529A	01	C, PSYCHOLOGY	05	68S00	MS	1	1	1	
529B	02	SECY (STENO)	06	00318	GS	1	1	1	
PSY INP & NEUROPSY SECTION									
529B	01	DIR NEURO SVS	03	68S00	MS	1	1	1	
529B	02	PSYCH IPS	03	68S00	MS	1	1	1	
529B	03	BEH SCI NCO	E6	91G30	NC	1	1	1	
529B	04	BEH SCI SP	E5	91G20	NC	1	1	1	
529B	05	BEH SCI SP	E4	91G20	EN	1	1	1	
529B	06	BEH SCI SP	E3	91G10	EN	1	1	1	
529B	51	PSYCH TECH	09	00181	GS	0	0	*	0
529B	51	PSYCHOLOGIST	12	00180	GS	0	0	*	0
529B	51	CLIN NEURO PSYCH	13	00180	GS	0	0		0
BEH MEDICINE SECTION									
529C	01	SUP, CLIN PSYCH	14	00180	GS	1	1	1	
529C	02	CLIN PSYCH	13	00180	GS	1	0	1	
529C	03	PSYCH TECH	09	00621	GS	1	1	0	
OUTPATIENT PSY SECTION									
529D	01	C, PSYCH (ADULT)	03	68S00	MS	1	1	1	
529D	02	C, PSYCH (PEDS)	03	68S00	MS	1	0	1	
529D	03	PSYCH (CHILD)	13	00180	GS	1	1	1	
529D	04	PSYCH (CHILD)	11	00180	GS	1	1	1	
529D	51	PSYCH (CHILD)	12	00180	GS	0	0	1	
TRNG & RESEARCH SECTION									
529E	01	DIR OF TRNG	04	68S00	MS	1	1	0	
529E	02	CLIN PSYCH INTERN	03	68U00	MS	[4]	4	4	

Note:

* CHAMPUS recapture position

Table 1
MED 302 Monthly Workload Prepared by PASBA

<u>CY 1987</u>	<u>01</u>	<u>02</u>	<u>03</u>	<u>04</u>	<u>05</u>	<u>06</u>	<u>07</u>	<u>08</u>	<u>09</u>	<u>10</u>	<u>11</u>	<u>12</u>
Inpt Vs	147	092	159	156	112	128	141	141	099	140	128	103
Outpt Vs	313	401	375	414	344	301	379	378	323	309	247	218
<u>CY 1988</u>	<u>01</u>	<u>02</u>	<u>03</u>	<u>04</u>	<u>05</u>	<u>06</u>	<u>07</u>	<u>08</u>	<u>09</u>	<u>10</u>	<u>11</u>	<u>12</u>
Inpt Vs	131	167	128	192	227	180	167	280	172	164	327	389
Outpt Vs	391	611	655	478	577	552	502	416	451	258	915	765
Psy Test	257	314	489	519	496	540	479	670	489			
<u>CY 1989</u>	<u>01</u>	<u>02</u>	<u>03</u>	<u>04</u>	<u>05</u>	<u>06</u>	<u>07</u>	<u>08</u>	<u>09</u>	<u>10</u>	<u>11</u>	<u>12</u>
Inpt Vs	319	398	348	270	316							
Outpt Vs	853	787	1023	879	923							
Psy Test		675	662	473								

Note: Inpt Vs = Inpatient Visits
 Outpt Vs = Outpatient Visits
 Psy Test = Weighted Work Units/Psychological Tests

Table 2
PSYCHOLOGY STAFF SATISFACTION SURVEY COMPARISONS

		<u>Main Effects (p)</u>		
		<u>Admin</u>	<u>Type</u>	<u>Interactions</u>
1. The extent I feel I am being utilized professionally.	ns	.001	ns	
2. The availability of adequate equipment supporting my job.	ns	.009	ns	
3. The availability of adequate support personnel.	ns	ns	ns	
4. Having a supportive duty environment.	ns	ns	ns	
5. My liking my present position.	ns	.049	ns	
6. The support of my co-workers.	ns	ns	ns	
7. The support of my supervisor.	ns	ns	ns	
8. Having cooperation from the departments that support my work.	ns	ns	ns	
9. Obtaining licensure/certification while on active duty.	ns	.003	ns	
10. Opportunity for self-improvement in my job.	ns	ns	ns	
11. The extent I make a meaningful contribution to my military organization.	ns	ns	ns	
12. The amount of responsibility given to me.	ns	ns	ns	
13. Having colleagues available for professional growth and development.	ns	ns	ns	
14. The extent of my positive attitudes toward the military in general.	ns	ns	ns	
15. Having opportunities for my personal growth and development.	ns	ns	ns	
16. Having opportunities available to work off duty (e.g. moonlight, teach, consult).	ns	.0001	ns	

		<u>Main Effects (p)</u>	
	<u>Admin</u>	<u>Type</u>	<u>Interactions</u>
17. The extent management is supportive of the staff.	ns	ns	ns
18. The morale of the professional staff members.	ns	ns	ns
19. The extent the staff know what is expected of them daily.	ns	.002	ns
20. The staff emphasis on providing quality patient care.	ns	.0001	ns
21. The degree to which work and time pressures dominate the job.	ns	ns	ns
22. The extent to which staff is supportive of one another.	ns	ns	ns
23. The extent to which staff is encouraged to be self sufficient.	ns	ns	ns
24. The opportunities for change and new approaches.	ns	.008	ns
25. The extent the physical surroundings contribute to staff satisfaction with the work environment.	ns	ns	ns
26. The extent our staff receives cooperation from other departments.	ns	ns	ns

Notes: Each situation has a scale continuum from MINIMUM (1) to MAXIMUM (7).

The variables examined were

Administrations of survey (Admin)

- 1) May 1988
- 2) November 1988
- 3) February 1989
- 4) May 1989

Type

- 1) Staff psychologists
- 2) Staff assistants/administrative persnl
- 3) In training

Analysis of variance comparisons were made (4x2); levels of significance (p) are reported (n=73). ns = non significant

Table 3
PSYCHOLOGY STAFF SATISFACTION SURVEY MEAN RESPONSES

		Mean Response				
	Overall	Staff Psy	Asst/ Admin	In Trng	P (signif)	
Cell Size:	73	33	24	16		
1. The extent I feel I am being utilized professionally.	4.4	4.8	3.3	5.2	.0009	
2. The availability of adequate equipment supporting my job.	3.9	4.4	4.0	2.9	.0049	
3. The availability of adequate support personnel.	3.7	3.5	4.0	3.6	ns	
4. Having a supportive duty environment.	4.7	4.6	4.9	4.7	ns	
5. My liking my present position.	4.9	4.4	5.3	5.5	.033	
6. The support of my co-workers.	5.4	5.2	5.7	5.5	ns	
7. The support of my supervisor.	5.4	5.3	5.5	5.8	ns	
8. Having cooperation from the departments that support my work.	4.5	4.7	4.1	4.5	ns	
9. Obtaining licensure/certification while on active duty.	4.2	4.8	3.1	4.4	.0028	
10. Opportunity for self-improvement in my job.	4.6	4.7	4.0	5.1	ns	
11. The extent I make a meaningful contribution to my military organization.	5.1	4.8	5.3	5.3	ns	
12. The amount of responsibility given to me.	4.9	4.9	4.9	4.9	ns	
13. Having colleagues available for professional growth and development.	5.0	5.1	4.7	5.3	ns	
14. The extent of my positive attitudes toward the military in general.	4.5	4.7	4.2	4.8	ns	
15. Having opportunities for my personal growth and development.	4.7	4.7	4.8	4.6	ns	
16. Having opportunities available to work off duty (e.g. moonlight, teach, consult).	4.2	4.1	5.6	2.4	.0001	

		<u>Mean Response</u>			
	<u>Overall</u>	<u>Staff</u>	<u>Asst/</u>	<u>In Trng</u>	<u>p</u> <u>(signif)</u>
Cell Size:	73	33	24	16	
17. The extent management is supportive of the staff.	4.5	4.3	4.7	4.5	ns
18. The morale of the professional staff members.	4.3	4.0	4.8	4.0	ns
19. The extent the staff know what is expected of them daily.	5.2	4.8	5.9	4.8	ns
20. The staff emphasis on providing quality patient care.	5.7	5.3	6.6	5.3	.0002
21. The degree to which work and time pressures dominate the job.	4.9	4.6	4.9	5.3	ns
22. The extent to which staff is supportive of one another.	4.9	4.9	4.7	5.0	ns
23. The extent to which staff is encouraged to be self sufficient.	5.3	5.4	5.2	5.3	ns
24. The opportunities for change and new approaches.	4.3	4.8	3.5	4.5	ns
25. The extent the physical surroundings contribute to staff satisfaction with the work environment.	3.9	4.1	3.9	3.3	ns
26. The extent our staff receives cooperation from other departments.	4.2	4.5	3.7	4.5	.043

Note: Each situation has a scale continuum from MINIMUM (1) to MAXIMUM (7).

Table 4
PSYCHOLOGY VERSUS PSYCHIATRY STAFF SATISFACTION SURVEY COMPARISONS

		<u>Main Effects (p)</u>		
		<u>Servc</u>	<u>Type</u>	<u>Interactions</u>
1. The extent I feel I am being utilized professionally.		ns	ns	ns
2. The availability of adequate equipment supporting my job.		ns	ns	ns
3. The availability of adequate support personnel.	.022	ns	ns	
4. Having a supportive duty environment.	ns	ns	ns	
5. My liking my present position.	ns	ns	ns	
6. The support of my co-workers.	ns	ns	ns	
7. The support of my supervisor.	ns	ns	ns	
8. Having cooperation from the departments that support my work.	ns	ns	ns	
9. Obtaining licensure/certification while on active duty.	ns	ns	ns	
10. Opportunity for self-improvement in my job.	ns	ns	ns	
11. The extent I make a meaningful contribution to my military organization.	ns	ns	ns	
12. The amount of responsibility given to me.	ns	ns	ns	
13. Having colleagues available for professional growth and development.	ns	ns	ns	
14. The extent of my positive attitudes toward the military in general.	ns	ns	ns	
15. Having opportunities for my personal growth and development.	ns	ns	ns	
16. Having opportunities available to work off duty (e.g. moonlight, teach, consult).	ns	ns	ns	

		<u>Main Effects (p)</u>	<u>Servc</u>	<u>Type</u>	<u>Interactions</u>
17.	The extent management is supportive of the staff.	.050		ns	ns
18.	The morale of the professional staff members.	ns		ns	ns
19.	The extent the staff know what is expected of them daily.	ns		.027	ns
20.	The staff emphasis on providing quality patient care.	ns		ns	ns
21.	The degree to which work and time pressures dominate the job.	ns		ns	ns
22.	The extent to which staff is supportive of one another.	ns		ns	ns
23.	The extent to which staff is encouraged to be self sufficient.	ns		ns	ns
24.	The opportunities for change and new approaches.	ns		ns	.018
25.	The extent the physical surroundings contribute to staff satisfaction with the work environment.	ns		ns	ns
26.	The extent our staff receives cooperation from other departments.	.007		ns	ns

Notes: Each situation has a scale continuum from MINIMUM (1) to MAXIMUM (7).

The variables examined were

Service (Servc)

1) Psychology Service

2) Psychiatry Department

Type

1) Staff (Psychologists, Psychiatrists)

2) Staff assistants/administrative personnel

3) In training

Analysis of variance comparisons were made (2x3); levels of significance (p) are reported (n=73). ns = non significant

Table 5
OUTPATIENT SATISFACTION SURVEY
MEAN VALUES AND COMPARISON BETWEEN BENEFICIARIES

<u>How satisfied were you with:</u>	<u>Mean Values</u> <u>Overall</u>	<u>Comparison</u>
		<u>p</u>
1 The clinic receptionist?	1.26	.036
2 The nursing staff?	1.25	ns
3 The care provider (Doctor, Registered Nurse, Physician Assistant, etc.)	1.13	ns
4 The overall care you received?	1.14	ns
5 The explanation of your problem?	1.23	ns
6 The explanation about your medications?	1.28	ns
7 The explanation of your treatment/ follow-up?	1.35	ns
8 The answers to your questions?	1.22	ns
9 The concern for your privacy?	1.11	ns
10 The appointment personnel?	1.16	ns
11 The medical records personnel?	1.25	ns
12 The laboratory staff?	1.55	ns
13 The x-ray staff?	1.42	ns
14 The pharmacy staff?	1.54	ns
15 The parking facilities?	1.80	ns
16 The directions within the hospital area?	1.63	ns

Note: Each situation has a scale continuum from (1) Very Satisfied, (2) Acceptable, (3) Dissatisfied.

<u>How satisfied were you with the waiting time:</u>	<u>Overall</u>	<u>D</u>
17 To obtain an appointment?	1.39	ns
18 At the medical records room?	1.47	ns
19 Before being seen for treatment?	1.42	ns
20 To have an x-ray taken?	1.62	ns
21 At the pharmacy?	2.00	ns
22 To have a laboratory test taken?	1.50	ns

Note: Each situation has a scale continuum from (1) Very Satisfied, (2) Acceptable, (3) Dissatisfied.

23 I normally receive my medical care at:	
Army	47
Navy	4
Air Force	7
missing	8
24 Walter Reed is a caring hospital	
yes	56
no	4
missing	6
25 In today's visit to Walter Reed, the staff were courteous	
yes	60
no	1
missing	5
26 In past visits to Walter Reed, the staff were courteous	
yes	51
no	5
missing	10

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APPENDIX 1

Memorandum for Assistant Secretary of the Army (M&RA)

SUBJECT: Establishment of a Separate Psychology Department



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

P.02

FV

15 JAN 1988

→	ZSO
→	DSO
→	XO
→	AXO (B)

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (M6RA)

SUBJECT: Establishment of a Separate Psychology Department at ~~the~~ 3
Walter Reed Army Medical Center

PSZ

Reb:

The National Defense Appropriations Act for Fiscal Year 1988 requires the establishment and evaluation of a separate Department of Psychology at an Army installation. In consultation with Doctor DeLeon, Administrative Assistant to Senator Daniel K. Inouye, I have determined that Walter Reed Army Medical Center is the appropriate location for conducting this evaluation. The Naval Hospital at Bethesda began a similar program on 1 May 1987 which provides a model for the Army effort. I am pleased to note that the Navy, in its first quarterly evaluation concluded that, "No problems are considered significant at this time." The Senate Appropriations Committee, with the concurrence of the conferees from the House Appropriations Committee, has now extended its original request to encompass similar demonstrations in the other Services.

I request that the Army develop a plan to establish a separate Psychology Department at Walter Reed Army Medical Center and that the plan be implemented not later than 1 May 1988. Further, I request that the method for evaluating the success of this approach be forwarded to this office. Again, I commend to you the plan developed at Bethesda. Please provide a semiannual brief report of benefits and problems, if any, in implementing this plan.

William Mayer, M.D.

CC:

Surgeon General, USA

APPENDIX 2
Implementation Plan Proposed by Walter Reed

Mission

1. To provide and coordinate psychological services for all patients with the highest standards of quality patient care. These services will include evaluation, diagnosis, treatment, consultation and disposition.
2. To conduct a Clinical Psychology Internship.

Functions

1. Office of the Chief

- a. Provide diagnosis, care, treatment and proper psychological disposition of patients.
- b. Provide consultation and training for all sections.
- c. Evaluate psychological care per AR 40-400.
- d. Conduct psychological research.
- e. Review and analyze work methods and operational procedures to ensure efficient, effective and safe utilization.
- f. Prepare and complete psychological records and reports.
- g. Maintain and conduct American Psychological Association accredited clinical psychology internship.
- h. Provide psychological consultation and coordination within WRAMC region.
- i. Provide leadership and administrative management of Psychology Service.

2. Psychiatric Inpatient and Neuropsychology Section

a. Neuropsychology

- (1) Provide neuropsychological evaluation for the full spectrum of cerebral conditions.
- (2) Provide counseling to patients and family members with neuropsychological problems.

b. Psychiatric Inpatient Psychology

- (1) Provide psychology liaison to Inpatient Psychiatry Service.
- (2) Conduct psychological and neuropsychological assessments in response to all consultation requests.
- (3) Participate in staffings, staff meetings and planning meetings.
- (4) Provide psychological support for the Champus Recapture program.

c. Provide training in assessment, treatment and management of psychiatric inpatients and in neuropsychological assessment to psychology interns.

3. Behavioral Medicine Consultation Section

- a. Conduct clinics in coordination with other services as directed by command.
- b. Provide assessment, diagnostic, consultation and treatment services to referred medical and surgical patients.
- c. Provide training and education in behavioral medicine to trainees and staff of a variety of disciplines.
- d. Provide assessment, diagnostic, consultative and treatment services to HIV patients.
- e. Provide neuropsychological evaluations on selected HIV patients.

4. Outpatient and Pediatric Psychology Section

a. Outpatient Psychology

- (1) Provide psychological assessment and treatment services to outpatient adults.
- (2) Coordinate referrals of selected patients with Outpatient Psychiatry Service.
- (3) Provide psychological assessment and consultation services to Outpatient Psychiatry, area Community Mental Health Activities/Services, and referred medical outpatients.
- (4) Provide consultation and psychotherapy services to the DOD designated Precision Fluency Shaping Program.

b. Pediatric Psychology

- (1) Provide professional psychological support to Child and Adolescent Psychiatry Service, Exceptional Family Member Program and Family Advocacy Program.
- (2) Provide psychological evaluation for referred pediatric patients.
- (3) Recommend/conduct treatment interventions for behavioral problems of pediatric inpatients.
- (4) Provide psychological treatment services to referred families.

5. Training and Research Section

- a. Conduct a one year, American Psychological Association accredited clinical psychology internship.
- b. Assist AFEDD Procurement in regional recruitment activities.
- c. Conduct training and education activities for officer, civilian and enlisted staff.
- d. Provide education and support to other professional training programs at WRAMC.
- e. Conduct psychological research and support other WRAMC research protocols.

APPENDIX 3
Evaluation Plans

Generic Outline for Evaluating the Effects of Structural Reorganization of Clinics, Services, Departments ("P's & Q's")

1. Identifying Data

- A. Mission Statement
- B. Personnel
 - 1) Recognized requirements
 - 2) Authorizations
 - 3) Assigned strength
 - 4) Contract personnel
- C. Training mission (GME/CME)
 - 1) Number of persons trained
 - a. Fulltime
 - b. Parttime
 - 2) Percentage of resources dedicated to support training mission
 - 3) Accreditation
- D. Readiness mission
 - 1) Personnel involved in readiness training
 - 2) Percentage of resources dedicated to support readiness training

2. Productivity

- A. Workload
 - 1) MED 302 report
 - a. Admissions
 - b. Occupied bed days
 - c. In-patient visits
 - d. Out-patient visits
 - e. Special categories
 - 2) DRG data
 - a. Case-mix index
 - b. Length of stay
 - c. Outliers
 - d. Other
 - 3) CHAMPUS workload
 - 4) Other data not otherwise captured
- B. Financial Data
 - 1) MEPRS accounts
 - a. Total costs
 - b. Shifts in sub-accounts
 - 2) Other

3. Quality

- A. Patient Issues
 - 1) Satisfaction (Questionnaire)
 - 2) Documented Complaints
 - 3) Malpractice Claims
- B. Provider Issues
 - 1) Satisfaction

- a. Questionnaire
 - b. Staff turnover
- 2) Credentialling
 - a. Licensure
 - b. Certification
 - c. Participation in CME
- 3) Teaching
 - a. % Time in teaching/supervision
 - b. Lecture time
- 4) Research
 - a. Publications
 - b. Protocols

C. Access

- 1) Waiting time for appointments by beneficiary category
- 2) Certificates of non-availability issued

D. External/Internal Quality Review

- 1) Internal peer review
- 2) DOD contract peer review
- 3) IG staff visits

WRAMC EVALUATION PLAN (PROPOSED)

1. Semiannual reports would be due 31 October and 30 April. Flexibility should be maintained to adjust the evaluation process as necessary.

A. Quality of Care Measures Goal: The Departments of Psychiatry and Psychology will continue to provide high quality patient care services.

Objective 1: total number of validated quality assurance screens will not increase.

Objective 2: total number of patient complaints registered will not increase.

B. Productivity Measures Goal: Productivity will not be adversely affected.

Objective 3: number of patient contacts reported per staff psychiatrist and resident will not decrease.

Objective 4: number of patients being accepted per provider for treatment will not decrease.

Objective 5: using current databases for gathering patient care statistics, productivity of Department of Psychology will not decline.

C. Efficiency Measures Goal: Duplication of work in clinical areas will be minimal.

Objective 6: less than 15% of patients triaged to Psychology will be referred back to Psychiatry for reevaluation and/or treatment (excludes referrals for admission/medications).

Objective 7: less than 15% of patients triaged to Psychiatry will be referred back to Psychology for re-evaluation and/or treatment (excludes referrals for neuropsychological/psychological assessment).

Objective 8: Psychology Departmental QA Minutes will be completed and forwarded in accordance with WRAMC SOP.

Objective 9: Current psychological/neuropsychological assessment consultation time standards will be maintained.

D. Utilization of Resources Measures Goal: Duplication of administrative support requirements will be kept to a minimum.

Objective 10: combined supply costs will not exceed current expenditures.

Objective 11: combined equipment costs will not exceed current expenditures (excludes equipment already ordered or currently planned to order).

E. Morale Measures Goal: Morale of both departments' will not be adversely affected.

Objective 12: a survey of both staffs will reflect substantial job satisfaction.

Objective 13: end of training year survey of psychology interns will reflect a substantial level of satisfaction with the internship meeting goals as stated in internship manual.

Objective 14: end of training year survey of psychiatry residents will reflect a substantial level of satisfaction with the residency meeting specified learning objectives.

F. Training Issues Goal: The departments shall continue to provide high quality training.

Objective 15: The Psychology Internship will meet training goals and maintain full American Psychological Accreditation.

Objective 16: The Psychiatric Residency Training Program will meet training goals and maintain full accreditation from the ACGME.

2. Data will be gathered semiannually, except objectives 13 + 14, and collated by DCCS for forwarding to higher authority.

<u>Objectives</u>	<u>DCCS</u>	<u>Psychiatry</u>	<u>Psychology</u>
Quality of care			
1. Validated quality assurance screens		X	X
2. Patient complaints	X		X
Productivity			
3. Patients contacts per psychiatrist	X		
4. Patients accepted for treatment	X		X
5. Psychology patient care statistics			X
Efficiency			
6. Referrals back to Psychology			X
7. Referrals back to Psychiatry	X		
8. Timely Psychology QA Minutes			X
9. Assessment Response timeliness			X
Utilization			
10. Supply costs	X		
11. Equipment costs	X		
Morale			
12. Staff satisfaction	X		X
13. Intern satisfaction			X
14. Resident satisfaction	X		
Training			
15. Psychology Accreditation			X
16. Psychiatry Accreditation	X		

APPENDIX 4
Staff Satisfaction Survey

Check one: _____ Date: _____
____ Staff Psychologist ____ Staff/Psych Asst, 91G, Admin ____ Psychology Intern

STAFF SATISFACTION SURVEY

Please consider how you feel now when responding to the following statements. Each item poses a condition. Please consider each item as it relates to your current assignment, job, or setting. Rate each SATISFACTION item as it relates to your military service. Interpret words or phrases as you wish; no need to editorialize with marginalia.

Do not spend a great deal of time deliberating over an answer. Usually, your first impressions are best. Please rate ALL of the situations. Each situation has a scale continuum from MINIMUM (1) to MAXIMUM (7). Please circle the one response for each item that BEST represents your feelings. Respond with the way you feel now.

	SATISFACTION							MAX
	MIN	1	2	3	4	5	6	
1. The extent I feel I am being utilized professionally.	1	2	3	1	5	6	7	
2. The availability of adequate equipment supporting my job.	1	2	3	4	5	6	7	
3. The availability of adequate support personnel.	1	2	3	4	5	6	7	
4. Having a supportive duty environment.	1	2	3	4	5	6	7	
5. My liking my present position.	1	2	3	4	5	6	7	
6. The support of my co-workers.	1	2	3	4	5	6	7	
7. The support of my supervisor.	1	2	3	4	5	6	7	
8. Having cooperation from the departments that support my work.	1	2	3	4	5	6	7	
9. Obtaining licensure/certification while on active duty.	1	2	3	4	5	6	7	
10. Opportunity for self-improvement in my job.	1	2	3	4	5	6	7	
11. The extent I make a meaningful contribution to my military organization.	1	2	3	4	5	6	7	
12. The amount of responsibility given to me.	1	2	3	4	5	6	7	
13. Having colleagues available for professional growth and development.	1	2	3	4	5	6	7	

	SATISFACTION							
	MIN	1	2	3	4	5	6	MAX
14. The extent of my positive attitudes toward the military in general.	1	2	3	4	5	6	7	
15. Having opportunities for my personal growth and development.	1	2	3	4	5	6	7	
16. Having opportunities available to work off duty (e.g. moonlight, teach, consult).	1	2	3	4	5	6	7	

The following statements involve your perceptions of your staff, co-workers, and the work environment. Each situation has a scale continuum from MINIMUM (1) to MAXIMUM (7). Please circle the one response for each item that BEST represents your feelings.

	MIN	1	2	3	4	5	6	7	MAX
17. The extent management is supportive of the staff.	1	2	3	4	5	6	7		
18. The morale of the professional staff members.	1	2	3	4	5	6	7		
19. The extent the staff know what is expected of them daily.	1	2	3	4	5	6	7		
20. The staff emphasis on providing quality patient care.	1	2	3	4	5	6	7		
21. The degree to which work and time pressures dominate the job.	1	2	3	4	5	6	7		
22. The extent to which staff is supportive of one another.	1	2	3	4	5	6	7		
23. The extent to which staff is encouraged to be self sufficient.	1	2	3	4	5	6	7		
24. The opportunities for change and new approaches.	1	2	3	4	5	6	7		
25. The extent the physical surroundings contribute to staff satisfaction with the work environment.	1	2	3	4	5	6	7		
26. The extent our staff receives cooperation from other departments.	1	2	3	4	5	6	7		

Describe here how you felt about your assignment, job when Psychology was a service, administratively in Department of Psychiatry.

Describe here how you expect to feel in the future in the administratively separate Department of Psychology.

Thank you very much for your cooperation in filling out this questionnaire.

APPENDIX 5
Psychology Staff Satisfaction Survey

Check one:

Staff Psychologist Staff/Psych Asst, 91G, Admin Psychology Intern

Date:

PSYCHOLOGY STAFF SATISFACTION SURVEY

Please consider how you feel now when responding to the following statements. Each item poses a condition. Please consider each item as it relates to your current assignment, job, or setting. Rate each SATISFACTION item as it relates to your military service. Interpret words or phrases as you wish; no need to editorialize with marginalia.

Do not spend a great deal of time deliberating over an answer. Usually, your first impressions are best. Please rate ALL of the situations. Each situation has a scale continuum from MINIMUM (1) to MAXIMUM (7). Please circle the one response for each item that BEST represents your feelings. Respond with the way you feel now.

	SATISFACTION						
	MIN	1	2	3	4	5	MAX
1. The extent I feel I am being utilized professionally.	1	2	3	4	5	6	7
2. The availability of adequate equipment supporting my job.	1	2	3	4	5	6	7
3. The availability of adequate support personnel.	1	2	3	4	5	6	7
4. Having a supportive duty environment.	1	2	3	4	5	6	7
5. My liking my present position.	1	2	3	4	5	6	7
6. The support of my co-workers.	1	2	3	4	5	6	7
7. The support of my supervisor.	1	2	3	4	5	6	7
8. Having cooperation from the departments that support my work.	1	2	3	4	5	6	7
9. Obtaining licensure/certification while on active duty.	1	2	3	4	5	6	7
10. Opportunity for self-improvement in my job.	1	2	3	4	5	6	7
11. The extent I make a meaningful contribution to my military organization.	1	2	3	4	5	6	7
12. The amount of responsibility given to me.	1	2	3	4	5	6	7
13. Having colleagues available for professional growth and development.	1	2	3	4	5	6	7
14. The extent of my positive attitudes toward the military in general.	1	2	3	4	5	6	7

	SATISFACTION							MAX
	MIN	1	2	3	4	5	6	7
15. Having opportunities for my personal growth and development.		1	2	3	4	5	6	7
16. Having opportunities available to work off duty (e.g. moonlight, teach, consult).		1	2	3	4	5	6	7

The following statements involve your perceptions of your staff, co-workers, and the work environment. Each situation has a scale continuum from MINIMUM (1) to MAXIMUM (7). Please circle the one response for each item that BEST represents your feelings.

	MIN	1	2	3	4	5	6	7	MAX
17. The extent management is supportive of the staff.		1	2	3	4	5	6	7	
18. The morale of the professional staff members.		1	2	3	4	5	6	7	
19. The extent the staff know what is expected of them daily.		1	2	3	4	5	6	7	
20. The staff emphasis on providing quality patient care.		1	2	3	4	5	6	7	
21. The degree to which work and time pressures dominate the job.		1	2	3	4	5	6	7	
22. The extent to which staff is supportive of one another.		1	2	3	4	5	6	7	
23. The extent to which staff is encouraged to be self sufficient.		1	2	3	4	5	6	7	
24. The opportunities for change and new approaches.		1	2	3	4	5	6	7	
25. The extent the physical surroundings contribute to staff satisfaction with the work environment.		1	2	3	4	5	6	7	
26. The extent our staff receives cooperation from other departments.		1	2	3	4	5	6	7	

Please read the following questions, and respond appropriately.

Have been assigned here ____ months.

Position: Officer, Enlisted, Civilian (circle one)

Direct care provider: yes no

Supervisor: yes no If yes, how many personnel? ____

Number of times taken this survey: ____ times

Describe here how you feel in the administratively separate Psychology Service.

How would you describe your current professional relationship with Psychiatry?

How has separating the Psychology Service affected Psychiatry?

How has separating the Psychology Service affected performing the missions of the Psychology Service?

What changes would you recommend be made?

Thank you very much for your cooperation in filling out this questionnaire.

APPENDIX 6
Psychiatry Staff Satisfaction Survey

Check one:
 Staff

Date: _____
 Staff Assoc/assistant In Training

PSYCHIATRY STAFF SATISFACTION SURVEY

Please consider how you feel now when responding to the following statements. Each item poses a condition. Please consider each item as it relates to your current assignment, job, or setting. Rate each SATISFACTION item as it relates to your military service. Interpret words or phrases as you wish; no need to editorialize with marginalia.

Do not spend a great deal of time deliberating over an answer. Usually, your first impressions are best. Please rate ALL of the situations. Each situation has a scale continuum from MINIMUM (1) to MAXIMUM (7). Please circle the one response for each item that BEST represents your feelings. Respond with the way you feel now.

	SATISFACTION						
	MIN	1	2	3	4	5	MAX
1. The extent I feel I am being utilized professionally.	1	2	3	4	5	6	7
2. The availability of adequate equipment supporting my job.	1	2	3	4	5	6	7
3. The availability of adequate support personnel.	1	2	3	4	5	6	7
4. Having a supportive duty environment.	1	2	3	4	5	6	7
5. My liking my present position.	1	2	3	4	5	6	7
6. The support of my co-workers.	1	2	3	4	5	6	7
7. The support of my supervisor.	1	2	3	4	5	6	7
8. Having cooperation from the departments that support my work.	1	2	3	4	5	6	7
9. Obtaining licensure/certification while on active duty.	1	2	3	4	5	6	7
10. Opportunity for self-improvement in my job.	1	2	3	4	5	6	7
11. The extent I make a meaningful contribution to my military organization.	1	2	3	4	5	6	7
12. The amount of responsibility given to me.	1	2	3	4	5	6	7
13. Having colleagues available for professional growth and development.	1	2	3	4	5	6	7
14. The extent of my positive attitudes toward the military in general.	1	2	3	4	5	6	7

	SATISFACTION							
	MIN	1	2	3	4	5	6	MAX
15. Having opportunities for my personal growth and development.	1	2	3	4	5	6	7	
16. Having opportunities available to work off duty (e.g. moonlight, teach, consult).	1	2	3	4	5	6	7	

The following statements involve your perceptions of your staff, co-workers, and the work environment. Each situation has a scale continuum from MINIMUM (1) to MAXIMUM (7). Please circle the one response for each item that BEST represents your feelings.

	MIN	1	2	3	4	5	6	7	MAX
17. The extent management is supportive of the staff.	1	2	3	4	5	6	7		
18. The morale of the professional staff members.	1	2	3	4	5	6	7		
19. The extent the staff know what is expected of them daily.	1	2	3	4	5	6	7		
20. The staff emphasis on providing quality patient care.	1	2	3	4	5	6	7		
21. The degree to which work and time pressures dominate the job.	1	2	3	4	5	6	7		
22. The extent to which staff is supportive of one another.	1	2	3	4	5	6	7		
23. The extent to which staff is encouraged to be self sufficient.	1	2	3	4	5	6	7		
24. The opportunities for change and new approaches.	1	2	3	4	5	6	7		
25. The extent the physical surroundings contribute to staff satisfaction with the work environment.	1	2	3	4	5	6	7		
26. The extent our staff receives cooperation from other departments.	1	2	3	4	5	6	7		

Please read the following questions, and respond appropriately.

Have been assigned here ____ months.

Position: Officer, Enlisted, Civilian (circle one)

Direct care provider: yes no

Supervisor: yes no If yes, how many personnel? ____

Number of times taken this survey: ____ times

Describe here how you feel in the Department of Psychiatry.

How would you describe your current professional relationship with Psychology?

How has separating the Psychology Service affected Psychology?

How has separating the Psychology Service affected performing the missions of the Department of Psychiatry?

What changes would you recommend be made?

Thank you very much for your cooperation in filing out this questionnaire.

APPENDIX 7
Patient Satisfaction Survey

OUTPATIENT SATISFACTION SURVEY

(HSC Rev 40-5)

CLINIC _____ HSC MTF _____ APPT _____ NON-APPT _____

STATUS

<input type="checkbox"/>	ACTIVE DUTY	<input type="checkbox"/>	ACTIVE DUTY DEPENDENT
<input type="checkbox"/>	RETIRED	<input type="checkbox"/>	RETIRED DEPENDENT
<input type="checkbox"/>	OTHER (civilian employee, civilian emergency, etc.)		

INFORMATION FROM THIS SURVEY WILL HELP US TO PROVIDE YOU THE BEST POSSIBLE MEDICAL CARE. To insure the accuracy of this survey, it is most important that you answer each question which applies to TODAY'S VISIT. It should take less than 3 minutes to complete the survey. All responses will be held in strictest confidence.

SECTION I

PLACE AN "X" IN THE APPROPRIATE BOX

TODAY'S VISIT			
VERY SATISFIED	ACCEPTABLE	DISSATISFIED	DOES NOT APPLY TO TODAY'S VISIT

HOW SATISFIED WERE YOU WITH:

1. The clinic receptionist?
2. The nursing staff?
3. The care provider (Doctor, Registered Nurse, Physician Assistant, etc.)
4. The overall care you received?
5. The explanation of your problem?
6. The explanation about your medications?
7. The explanation of your treatment/follow-up?
8. The answers to your questions?
9. The concern for your privacy?
10. The appointment personnel?
11. The medical records personnel?
12. The laboratory staff?
13. The x-ray staff?
14. The pharmacy staff?
15. The parking facilities?
16. The directions within the hospital area?

HOW SATISFIED WERE YOU WITH THE WAITING TIME:

17. To obtain an appointment?
18. At the medical records room?
19. Before being seen for treatment?
20. To have an x-ray taken?
21. At the pharmacy?
22. To have a laboratory test taken?

SECTION II (For local use overprint)

ARMY NAVY AF
ARMY NAVY A.F.

23. I normally receive my medical care at (check one)

AGREE DISAGREE

24. Walter Reed is a caring hospital (check one)

IF YOU HAVE ANY ADDITIONAL COMMENTS OR SUGGESTIONS, PLEASE WRITE THEM ON THE REVERSE.

Please deposit your completed survey form in the box provided at the Pharmacy, X-Ray or Laboratory. Thank you for taking time to answer this survey.

APPENDIX 8
WRAMC Quality Assurance Program

Psychology Service Quality Assurance Plan

1. References:

- a. AR 40-66
- b. WRAMC Reg 40-60
- c. WRAMC Reg 40-92
- d. JCAH Manual
- e. JCAH Quality Review Bulletin, Sep 1986

2. Responsibility: Barry N. Blum, LTC, 6-1065, has been appointed by the Chief, Psychology Service as the service's Quality Assurance Coordinator. He shall be responsible for coordinating all monitoring and evaluation of the quality and appropriateness of care in this separate service. He shall be assisted by the following individuals in subordinate areas:

NCOIC, Psychology Svc	SGT Audrey Troup, 6-1065
Behavioral Medicine	William Grace, GS 12, 6-1741
Neuropsychology	Raymond A. Parker, LTC 6-1065
Psychiatric Inpatient	Mark Purviance, CPT, 6-1065
Outpatient and Pediatric	
Psychology	Deborah Nunnally-Blowe, CPT 6-1066

Relief of any of the above individuals will be in writing from the C, Psychology Service to the Service QA Coordinator with a copy to the WRAMC QA/RM Coordinator.

3. Scope of Care:

A. Major areas of service provided.

- (1) Outpatient treatment, evaluation, diagnosis and disposition.
- (2) Psychological consultation and treatment for referred medical, surgical and other patients.
- (3) Psychological and neuropsychological assessment and consultation for psychiatric, medical/surgical and pediatric patients.

B. Patients served predominantly those with actual/suspected psychiatric, neurologic, neurosurgical, orthopedic, pain syndrome, marital/family or developmental problems.

C. Patient care activities are:

psychological assessment and diagnosis
neuropsychological assessment and diagnosis
psychotherapy
group psychotherapy
marital and family therapy
hypnotherapy
biofeedback
sexual dysfunction therapy

4. Important Aspects of Care.

A. Formal requests for psychological assessment of patients are answered in an appropriate and timely manner.

(1) Indicator: Written replies on SF 513 Consultation Sheets requesting psychological assessment are drafted within 5 working days following completion of assessment - 90% Compliance.

(2) Indicator: Assessment Procedures selected are clinically appropriate to the assessment being requested - 90% Compliance.

(3) Indicator: Interpretations and conclusions are congruent with data obtained - 90% Compliance.

(4) Data Source: Psychology Service Assessment Files; Psychology Service Data Base Records.

(5) Collection Method & Sample: A representative sample of Psychology Service Assessments initiated in response to a health care provider's SF 513 request will be reviewed on a regularly basis.

B. Patients seen for initial intake are evaluated for potential for self-harm and/or harm to others.

(1) Indicator: Pt questioned regarding current suicidal/homocidal ideation or intent - 90% compliance.

(2) Indicator: Pt questioned regarding history of past significant suicidal/homocidal ideation, intent, or actual attempts - 90% compliance.

(3) Indicator: Patient questioned regarding recent suicide/homicide attempts or completions by family members or close friends - 80% compliance.

(4) Data Source: Psychology Service Treatment Files.

(5) Collection Method & Sample: On a regular basis all intakes seen by Psychology Service over a preceding, specified period long enough to furnish a representative sample will be reviewed.

C. Patient's medical status is reviewed and addressed appropriately.

(1) Indicator: Review of patient's medical status and significant medical history during initial intake is documented in service file - 90% compliance.

(2) Indicator: Consultation with physician for adjunctive medical assessment or treatment occurs when any of the following apply: (90% compliance):

a. Patient used or is using psychotropic medication in last 6 months.

b. Sexual dysfunction present and not currently being treated.

- c. Suspected abuse of medication or other drugs within last 6 months.
- d. Psychiatric hospitalization within last six months.
- e. Reported physical condition which may relate to current psychiatric symptoms.
- f. Psychiatric symptoms suggest possible need for psychiatric hospitalization, medication, or other somatic therapy.
- g. Presenting complaints suggest possible physical disorder requiring treatment.

(3) Data Source: Psychology Service Treatment Files.

(4) Collection Method & Sample: On a regular basis a representative sample of intake and treatment charts will undergo peer review.

D. Psychometric procedures will be accurately administered and scored.

(1) Indicator: No clinically significant errors occur - 95% compliance.

(2) Data Source: Psychology Service Assessment Charts.

(3) Collection Method & Sample: On a regular basis a random, representative sample of assessment cases will be selected for review. Specific psychometric procedures prone to administration and scoring errors will be designated for examination and rescoreing during each review to check for accuracy.

E. Potentially critical incidents during intake and treatment processes will be monitored and evaluated to ensure that both frequency and specific circumstances of occurrence are consistent with quality treatment. Potentially critical occurrences include: (a) completed suicide/homicide, (b) attempted suicide/homicide, (c) psychiatric hospitalization of a Psychology Service treatment outpatient, (d) emergency room visit by a Psychology Service treatment outpatient during non-duty hours for psychologic reasons.

(1) Indicator: Completed suicide/homicide - 0% occurrence.

(2) Indicator: Attempted suicide/homicide - no more than 2 incidents per month, 3 incidents in any 3 month period, or 5 incidents in any 6 month period for any health care provider.

(3) Indicator: Psychiatric hospitalization and/or emergency room visit - no more than 3 incidents per month or 6 incidents in any 3 month period, or 8 incidents in any 6 month period for any health care provider.

(4) Data Source: Psychology Service Data Base; Psychology Service Case Conference, Supervision Sessions.

(5) Collection Method & Sample: All potentially critical incidents will be reported and discussed in the Psychology Service Case Conference or in supervision discussions. All such incidents will also be noted in the Psychology Service Data Base. All such incidents will also be reported at each QA meeting for the preceeding month along with the frequency of such incidents for the health-care provider in question for the proceeding six months.

5. Problem Solving: When any of the indicators for the important aspects of care exceeds its threshold, the next disinterested psychologist on a roster of credentialed psychologists assigned to Psychology Service will be tasked to: evaluate the case(s) failing to meet the standard of care; and provide a written summary of the evaluation, to include a conclusion (i.e., probable cause of problem, whether it was avoidable/preventable), recommendations (e.g., on procedures and/or provider training needs), other actions required and method of follow up.

6. Impact on Patient Care: The Quality Assurance Committee will evaluate, semiannually, in November and May, the impact that monitoring is having on patient care and of any corrective actions taken.

7. Report: Psychology Service Quality Assurance Committee will report on potentially critical incidents once monthly. Other important aspects of care will be investigated on a regular, rotating basis. More focused or targeted investigations of clinically relevant topics will be scheduled at least once annually.

*Bryan H. Blum, Asst. Ch.
for*

BRIAN H. CHERMOL
COL, MS
Chief, Psychology Service

CF: WRAMC QA/RM Coordinator